Complaint Form

Office of Health Facility Complaints (OHFC)

P.O. Box 64970
St. Paul, MN 55164-0970

(651) 201-4201, 1-800-369-7994
Fax- (651) 281-9796, **TDD-** (651) 201-5797

To assist you with your complaint, the MN Department of Health requests that you complete this form and return it in the enclosed envelope. The information you provide may be used in an effort to resolve the problem, to request additional information or to prompt an on-site investigation. OHFC must prioritize complaints that are received, and therefore is not able to investigate every complaint. Your complaint will be reviewed and you will be notified of our course of action. Regardless of the outcome of your complaint, information you provide will be placed in the facility's file in OHFC.

Please print clearly, using black ink

Your name:____

Address_____________________________________ Home Phone# ( )_____________

City__________________ State______ Zip________ Work Phone# ( )_____________

Complaint is on behalf of:___________________________ or ☐ Yourself
(Patient/Resident Name)

Patient/Resident Date of Birth__________________ Gender M / F (circle one)

Relationship to Patient/Resident (Ex: spouse, sibling, child, friend, etc.)______________

Facility involved in your complaint: (Hospitals, Nursing Homes, Home Care Agencies, Assisted Living Facilities, ICF/MR, SLF)

Name of Facility/Agency____

Address (if available)____

What part of the facility concerns you? (name unit, floor or location, if applicable)_____________

The room Number/Unit of the resident or patient, if known or applicable_____________

The date that the identified incident occurred (please include year)_______________

Do you know what type of license the facility holds? (i.e. hospital, nursing home, home care agency, Assisted living, ICFMR, SLFA)____

What would you like to see happen to resolve this complaint?

Have you contacted any other agency to help resolve this complaint?
What Agency?

If your concern involves home care, please provide a copy of the clients home care contract, if possible.

Narrative description of your complaint: Please describe what occurred, where and when the incident transpired and who was involved. Include in your description if you witnessed the incident or if it was described to you by someone else. Include copies of any documents you think will be helpful to us. If possible, please include the identity of anyone involved and their job title if they are staff (first names are acceptable if you do not have full names). If the complaint involves a death, please include a copy of the death certificate, if possible.

TENNESSEN WARNING
The information you provide on this form may be used in an investigative report, however your identity is confidential and is not revealed to the general public, except as required by law.

Some information may be private data and may be made available only to other state and/or federal agencies, law enforcement, the Attorney General's Office, health licensing boards, the Nurse Aid Registry and/or the Minnesota Department of Human Services. If is possible that your identity might be revealed to persons participating in a hearing if a determination should result in a hearing.

You are not legally required to provide this information, but failure to do so may hinder efforts to resolve the problem.

The information I have given is true and accurate to the best of my knowledge and may be used as stated in this form.

______________________________________ ______________________

Signature **Date**

Narrative Description of Complaint :

Attach additional sheets as necessary. Revised - 2/07